CHAPTER V - HOME HEALTH PROSPECTIVE PAYMENT SYSTEM MEDICAL REVIEW

OBJECTIVE

The objective of this chapter is to provide participants with the needed information regarding medical review under HH PPS.

Participants will learn the following:

1. Goals and scope of medical review;
2. Types of medical review;
3. Eligibility and coverage requirements;
4. Medical documentation request procedures;
5. Plan of care (POC) and physician order requirements;
6. Significant Change In Condition (SCIC);
7. Medical review process.

GOALS AND SCOPE OF MEDICAL REVIEW

The Balanced Budget Act (BBA) of 1997, as amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999, mandates the implementation of home health prospective payment (HH PPS) for services provided on or after October 1, 2000. HH PPS replaces the retrospective reasonable-cost-based system currently used by Medicare for payment of the home health services. Section 1816 of the Social Security Act requires Regional Home Health Intermediaries (RHHIs) to conduct audits of providers' records as needed to ensure that payments are proper.

Effective with dates of service on or after October 1, 2000, HH PPS medical review requirements begin.

The financial incentives available to an HHA change from overutilization to underutilization under an episode-based PPS. The RHHIs will work collaboratively with the state survey agencies to assure quality of care issues resulting from under-service are addressed swiftly and completely.

The goal of medical review is to determine whether services provided are reasonable and necessary, delivered and coded correctly, and appropriately documented.

TYPES OF MEDICAL REVIEW

The specifics of the home health medical review strategy are not yet finalized although it is anticipated the strategy will include many of the same types of review that are currently conducted.

RHHIs will continue to conduct data analysis to assist in targeting areas that represent the best investment of medical review resources. The RHHIs will analyze home health billing information and will consider data from internal or external sources (e.g., provider audit, fraud and abuse units, beneficiary or other

complaints) to ensure medical review efforts are targeted where there is the greatest risk to the Medicare trust funds.

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Initially, a blend of pre-payment and post-payment basis medical review is being considered. The medical review process will be conducted on a random and targeted basis.

Random review will allow RHHIs to identify normal provider billing practice patterns as well as potential payment errors under the new system. The information gained will be used to formulate educational interventions, and aid in developing further review strategies.

Targeted review may be focused on areas such as:

- Identified Program vulnerabilities
- Provider specific aberrancies
- Newly participating providers
- Referrals from state survey agencies
- Other areas as they are identified

ELIGIBILITY AND COVERAGE REQUIREMENTS

The New HH PPS Guidelines do not Change the Existing Medicare Eligibility or Coverage Requirements.

The new HH PPS guidelines do not change the existing Medicare eligibility or coverage requirements. To qualify for Medicare coverage of home health services, a beneficiary must meet the following criteria:

1. The patient must be homebound. An individual does not have to be bedridden to be considered homebound; however, the condition of the patient should be such that a normal inability to leave home exists and, consequently leaving home requires a considerable and taxing effort. Absences from the home are allowed, but they must be infrequent, of short duration, and/or to receive medical treatment.

2. Services are provided under an established and approved physician Plan of Care (POC). The POC

must contain all pertinent diagnoses and the services, supplies, equipment, etc. The orders on the POC must specify the type of services to be provided to the patient, as well as the frequency of the services. In addition, all orders must identify the professional providing the service.

3. The HHA must be acting upon a physician certification that is part of a POC (HCFA-485).

4. The beneficiary requires intermittent skilled nursing, Speech-Language Pathology, Physical Therapy, or a continuing need for Occupational Therapy.

5. The services provided to a beneficiary must be medically reasonable and necessary for the treatment of the patient's illness or injury.

6. The services must not be statutorily excluded from coverage under the Medicare home health benefit.

MEDICAL DOCUMENTATION REQUEST PROCEDURES

The Medical Review Department Will Issue a Request for Medical Documentation.

If a Request for Anticipated Payment (RAP) or final claim is selected for medical review, the Medical Review Department will issue a request for medical documentation. The documentation request will identify a timeframe to respond. An HHA will not send medical records with the home health claim unless they are requested.

Requested documentation may include, but is not limited to, the following information:

- Valid POC (HCFA-485)

- Physician orders for services not included in the POC

- OASIS Assessment (If more than one OASIS assessment was performed during the episode, the additional assessment will be submitted with the documentation. The additional assessments

are needed to assist medical reviewers in validating SCICs.)

- Clinical notes for all disciplines
- Treatment and flow charts and vital sign records
- Weight charts and medication records
- Any other home health medical documentation to support payment and coverage

Medical Review Determinations are Based on the Documentation Submitted by the Home Health Agency

Medical review determinations are based on the documentation submitted by the HHA.

PLAN OF CARE AND PHYSICIAN ORDER REQUIREMENTS

The Advent of PPS Modified the Recertification Process to Reflect the 60-Day Episode

Formerly, the POC was recertified every 62 days or every two calendar months, and it excluded the "through day" from the certification period. The advent of PPS modified the recertification process to reflect the 60-day episode. The 60-day episode begins with the first Medicare billable visit as day 1 and ends on and includes the 60th day from the start of care date. Recertification begins on day 61 and ends on and includes day 120, etc.

Under PPS, the POC must be reviewed and signed by the physician every 60 days unless one of the following occurs:

- A beneficiary transfers to another HHA
- A SCIC resulting in a change in the case-mix assignment
- A discharge and return to the same HHA during the 60-day episode

In order to ease the transition to PPS for beneficiaries under an established OASIS assessment and certified POC prior to PPS implementation on

October 1, 2000, a one-time grace period will be granted.

If a beneficiary is under an established home health POC before October 1, 2000, and the certification date is on or after September 1, 2000 and the HHA, in conjunction with a certifying physician, does not wish to do a one time additional recertification of the plan of care at the inception of PPS, the HHA may use the recertification date (September 1, 2000 through September 30, 2000) from the earlier version of the POC.

A beneficiary under an established POC as of September 1, 2000, may have a one-time implementation grace period for the POC certification requirements for a maximum period of up to 90 days. (September 1, 2000 through and including November 29, 2000)

If a provider chooses to utilize the one-time grace period, the orders on the POC must clearly reflect a break at October 1, 2000. The orders must specify the services to be provided by the HHA up to and including September 30, 2000, and the services to be provided on and after October 1, 2000.

Claims for dates of service prior to October 1, 2000, are subject to the requirement of having the POC signed and dated by the physician prior to billing the services to Medicare.

For each 60-day episode the HHA must submit a RAP and a final claim unless the provider determines it will not exceed the Low Utilization Payment Adjustment (LUPA) threshold (4 or fewer visits). In LUPA cases, they may submit a final claim without submitting a RAP. This will be called a “no-RAP-LUPA” claim.

A RAP is a Request for the Initial Percentage Payment and it is not Considered a Claim

A RAP is a request for the initial percentage payment and it is not considered a claim, and it is not subject to the requirement that the POC be signed and dated by the physician before the HHA submits it. If the physician signed POC is not available at the time the HHA requests an anticipated payment, the initial percentage prospective payment (in accordance with Section 484.205) must be based on:

A. A physician's verbal order that:
   1. Is recorded in the plan of care;
   2. Includes a description of the patient's condition and the services to be provided by the HHA;
   3. Includes an attestation (relating to the physician's orders and the date received) signed and dated by the registered nurse or qualified therapist (as defined in 42 CFR 484.4) responsible for furnishing or supervising the ordered service in the POC; and
   4. Is copied in the POC and the POC is immediately submitted to the physician; or

B. A referral prescribing detailed orders for the services to be rendered that is signed and dated by a physician.

The Final Claim Contains the Final Percentage Payment and is Subject to the Current Physician Signature Requirements

A RAP is a "claim" for purposes of Federal, civil, criminal, and administrative law enforcement authorities, including but not limited to the Civil Monetary Penalties Law (as defined in 42 U.S.C. 1320-7a (i) (2)), and the Civil False Claims Act (as defined in 31 U.S.C. 3729(c)), and the Criminal False Claims Act (18 U.S.C. 287)).

The final claim contains the final percentage payment and is subject to the current physician signature requirements.

All Services Provided by a HHA Must be Provided Based on Physician Orders

All services provided by an HHA must be provided based on physician orders. Written and verbal orders not included in the POC (HCFA-485) must be signed and dated by the physician prior to the submission of the final claim.

SIGNIFICANT CHANGE IN CONDITION

A Change in the Patient's Condition Must be Significant Enough to Impact the POC and Result in a Change in the Case Mix Level

This adjustment occurs when a beneficiary experiences a Significant Change in Condition (SCIC) during a 60-day episode that was not envisioned in the original POC. In order to receive a new case-mix assignment for purposes of SCIC payment during the 60-day episode, the HHA must complete an OASIS assessment and obtain the necessary physician orders reflecting the significant change in treatment approach in the patient's POC. It is important to keep in mind that the change in the patient's condition must be significant enough to impact the POC and result in a change in the case mix level. Minor changes that would be considered a normal part of the original POC would not justify a SCIC adjustment.

SCIC Example

A patient is admitted to an HHA with a new diagnosis of CHF for skilled observation and assessment, skilled instruction regarding medications and diagnosis. On day 20 of the episode, the patient experiences a fall, which results in a broken ankle. Physical therapy is needed for gait training with a walker, transfer training and therapeutic exercises. Physical therapy visits begin on day 23.

This would represent a change significant enough to warrant a new case-mix assignment for payment. The HHA should complete an OASIS assessment and obtain the appropriate physician's orders. The first part of the episode would be paid at the original HRG level from day 1 to day 20 when the last billable service was performed. The second part of the episode will be paid at the new case mix level from the date of the first billable visit at the new level through the balance of the episode. Days 23 through day 60 are paid at the new HRG level.

It is Possible that There Could Exist a Situation Where More than One SCIC Adjustment Could Occur During a Single 60-Day Episode Period, However it is Anticipated that this Would be a Rare Occurrence

It is possible that there could exist a situation where more than one SCIC adjustment could occur during a single 60-day episode period, however it is anticipated that this would be a rare occurrence. RHHI's will monitor billing patterns, abberancies and potential abuse under the new payment system.

MEDICAL REVIEW PROCESS

Medical review is a multifaceted process that includes an evaluation of the RAP/claim and its associated medical records.

Medical Review is a Multifaceted Process

Provider submitted documentation is used to determine the beneficiary's eligibility and coverage. Important elements of the medical review process are:

- **Eligibility and coverage requirements-** see discussion on pages 3-4. This information should be clearly reflected in the patient's clinical record.
- **OASIS validation-** the clinical condition indicated in the OASIS should be consistent with the beneficiary's clinical record.
- **Medical necessity-** the services billed by an HHA must be medically necessary to ensure the beneficiary is properly classified into the appropriate HRG category.
- **Supplies-** supply costs are incorporated into the payment rate for the episode and HHAs are required to provide all necessary supplies.
- **Durable Medical Equipment (DME)-** the Balanced Budget Refinement Act (BBRA) removed DME from the consolidated billing

requirement. If an HHA bills for DME on its claim, the HHA will be reimbursed on a fee schedule basis. DME requires a valid physician's order and must be medically reasonable and necessary for the patient's medical condition.

- **Exclusions-** Services must not be statutorily excluded under Medicare.

Education is the key to ensure proper billing of home health claims and prevent future billing errors. As problems are identified, RHHIs will not only educate individual providers, but also the home health community about the common problems found through medical review.